GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE PLANS

TEFRA PROGRAM

A Waiver Request Submitted Under the Authority of
Section 1115 (a) of the Social Security Act

To

Division of Integrated Services
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

January 2004

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SECTION 1115 (a) RESEARCH AND DEMONSTRATION
WAIVER APPLICATION
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
TEFRA DEMONSTRATION

I. EXECUTIVE SUMMARY

The Georgia Department of Community Health is proposing a Section 1115(a) demonstration waiver for a period of five (5) years to impose cost sharing requirements on children age 18 and under who are otherwise eligible for Medicaid under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), except where noted in the Eligibility Requirements section below. Parent(s), guardian(s) or custodian(s) whose children qualify for another Medicaid category with coverage comparable to the waiver services will be allowed to choose the regular Medicaid Program or the waiver program for their child. The proposed implementation date for the waiver is April 1, 2004.

The objective of DCH is to replace the TEFRA eligibility category with an alternative category. The following describes the proposed program:

A. Families of eligible children will not be required to drop their existing insurance. Any family who voluntarily drops creditable health insurance coverage for the waiver child will be ineligible for waiver benefits for the child with a disability for a period of six (6) months from the date the insurance is dropped. Recipients who have dropped insurance since the last annual review will lose six (6) months of coverage beginning with the month after the month of discovery.

B. There will be no cap on the number of children served.

C. Cost sharing measures will be based on the adjusted gross income of the custodial parent(s) as reflected on the most recently filed IRS Federal Tax Return (1040 or 1040A). Documentation provided will also include any late or amended returns.

D. Recipients under the waiver will receive the full range of Medicaid benefits and services as described in the Georgia Title XlX State Plan

II. PUBLIC NOTICE

A public notice was released for print to Georgia newspapers on January 14, 2004. The notice was also available for review during the 30-day public comment period at each county Department of Family and Children Services office. (See Attachment A for the list of Georgia newspapers, and Attachment B for a copy of the Public Notice.)

III. THE ENVIRONMENT

A. Overview of Current System

The population to be served by the waiver is currently receiving services under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

B. Experience with State Waivers

The state is currently operating the following waivers:

1. 1915(b)

    a. MH/MR Preadmission Screening and Annual Review (PASAAR) Program
    b. Georgia Better Health Care
    c. Non-Emergency Transportation

2. 1915(c)

    a. Georgia HCBS Waiver: Aged and Disabled (0112)
    b. Georgia HCBS Waiver: MR/DD (0175)
    c. Georgia HCBS Waiver: MR/DD (0323)
    d. Georgia HCBS Waiver: Severely Physically Disabled and Traumatic Brain Injury

The waivers listed above have been well received and there have been no major problems experienced with them.

C. State Budget

1. What is the financial outlook of the current Medical program?

    The financial outlook for the Georgia Medicaid program is similar to that of a number states (e.g., New Jersey, Mississippi and Missouri). As in many other states the finances will be tight for the next couple of years. Georgia believes we can maintain essential services, including medically necessary services for children.

2. Can the State sustain adequate financing for the life of the waiver?

    We believe, with known factors at this date, Georgia can maintain funding for this waiver.

IV. PROGRAM ADMINISTRATION

The demonstration will be administered by the Division of Medical Assistance Plans (DMA), a Division of the Georgia Department of Community Health. (See Attachment C. for a copy of the DCH organizational chart.)

The Division of Medical Assistance Plans is responsible for ensuring compliance with the waiver in regard to services, provider participation, and eligibility policy.

The Department of Community Health has an interagency agreement with the Department of Human Resources (DHR) to handle Medicaid eligibility determinations, including TEFRA. This process is handled through the DHR Division of Family and Children Services (DFCS) in their county offices. The application process, which includes taking the application, interviewing and requesting the information necessary for processing the cases, currently in place in the local DFCS offices will continue.

V. ELIGIBILITY

A. Age

The child must be age 18 or younger

B. Disability

The child must be disabled according to the SSI definition;

C. Citizenship

The child must be a U.S. citizen or a qualified alien;

D. Residency

The child must be a Georgia resident;

F. Social Security Number

The child must have an SSN or apply for one;

G. Income

The child's gross countable income must be less than the current Long Term Care (LTC) income limit ($1692 per month in 2004), i.e., the child would be Medicaid eligible if institutionalized. Parental income is not considered in the eligibility

determination but is considered for the purpose of calculating the monthly premium. See Section VI B.

H. Assets

The child's countable assets cannot exceed $2000. The assets of the parent(s) are not considered.

I. Payment of Premiums

The parent(s) will be required to pay monthly premiums through bank drafts or quarterly payments in advance. For new recipients, premiums will be applied beginning with the month following the month of approval. Premiums will not be charged for the approval month or covered months prior to the month of approval. When approved, DCH will send a notice to the parents(s) giving the option of authorizing an automatic bank draft or making quarterly payments in advance.

For those parents who choose to pay through monthly bank drafts, DCH will draft the account for the two months following the month of approval. After which, DCH will make monthly drafts to the account in the month prior to the covered month.

For those who choose quarterly payments, the parent must initially pay for the four months following the month of approval. After which, DCH will send quarterly notices requesting premium payment in the month prior to the covered quarter. If eligibility ends during the quarter, any premiums already paid for months after the month of closure will be reimbursed to the family.

Failure to provide bank draft information or make the initial quarterly payment will render the child ineligible and the case will be closed after advance notice. For ongoing cases, if the premium is not paid for three (3) months (either the bank account has had insufficient funds to draft or the parent has not made the quarterly payment), the case will be closed. Monthly aged reports will be sent to each county showing the case with overdue premiums and the number of payments in arrears. The county caseworker will send an advance notice of case closure to those that are 3 months in arrears and close the case if the premium is not paid within the notice period. During months that premiums are in arrears, the child will remain eligible and providers will be paid.

If a case is closed due to non-payment of the premium, the parent must reapply and eligibility will be re-determined at the point of reapplication. If a new application is made within 12 months from the date of case closure, premiums will be due for the three (3) months of arrearages.

J. Dropped Health Insurance Coverage

A child can receive TEFRA Waiver services and retain health insurance. Any family who voluntarily drops creditable health insurance coverage for the waiver child will

be ineligible for waiver benefits for the child with a disability for a period of six (6) months from the date the insurance is dropped. At the yearly reevaluation, if it is determined that health insurance coverage was voluntarily dropped after the case was approved, the case will be closed for six (6) months beginning with the month following the month of discovery.

The six-month period of ineligibility will apply unless one of the following conditions is met:

1. The health insurance is a non-group or non-employer sponsored plan.

2. The health insurance was lost through termination of employment for any reason.

3. The health insurance was lost through no fault of the custodial parent(s), guardian or custodian. For example, the employer ceases to provide employer sponsored health insurance, the non-custodial parent carried the insurance and dropped it, the maximum benefit limit for the child has been reached etc.

K. Medical Necessity

The child either meet the medical necessity requirement for institutional placement, or level of care, for institutional placement. The determination of medical necessity will also be based upon services that improve, maintain or prevent regression of the child's health status and be based upon the child's medical, health and family situation. The entire family home life must be considered when determining the needs of the child and family impact. The Medical Necessity Determinations Team will be comprised of appropriate pediatric specialists with relevant experience in dealing with children with chronic illnesses.

For the purpose of this waiver, the institutional placement or level of care will include:

1. Hospital; or

2. A nursing facility; or

3. ICF/MR

The child must have access to medical care in the home. It must be deemed appropriate to provide such care outside an institution; and

The estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

VI. BENEFITS

A. Benefit Package

Eligible children will receive the full range of Medicaid services through the waiver.

B. Premiums

All waiver recipients will pay a monthly premium. The amount of the premium will be based on the custodial parent(s) adjusted gross income as reported on the applicable Federal Income Tax Return less the following deductions:

1. Six hundred dollars ($600) per child (biological or adopted) who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parent(s); and

2. Excess Medical and dental expenses as itemized on Schedule A of the Federal Income Tax Return of the parent(s).

The maximum annual premium amount to be paid by any family is $5,500. Families that have more than one child receiving TEFRA waiver benefits and services will pay only one premium for additional waiver children. (See Attachment F for the amount of the premiums to be paid.)

For late or amended returns that result in an increased premium, the increase shall be retroactive to the date that the initial return would have been due in the absence of an extension. Failure to supply required tax information shall render the child ineligible.

The premium will begin in the month following the month eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. Income will be reviewed annually, for purposes of calculating the premium; or, when there is a change that will make a difference of more than 10% in annual household income. An adjustment can be made to the premium during the year if the parents report a significant change in excess of 10% of expected annual income. Income that fluctuates due to the type of employment, e.g. teachers, farmers, etc., will not affect the monthly premium. The premium can only be adjusted at a maximum of once every 6 months.

The parent(s) will be required to pay monthly premiums through bank drafts or quarterly payments in advance. The premium must be paid in the month preceding the covered month or quarter. The child's case will not be closed and providers will continue to be reimbursed for covered services if the premium is not paid for three (3) months.

If after three (3) months, premiums are in arrears, coverage will be terminated following appropriate advance notice. If payment of all premiums in arrears is not made and the case closes, then the parent must reapply and eligibility will be determined at the point of application.

If the case has been closed less than 12 months because of premium payments in arrears, the three (3) months past due premiums must be paid before the child can again be approved for TEFRA Waiver services.

If a case is closed 12 months or more because of Premium payments in arrears, payment of the past due premiums will not be required.

A. Special Populations

The population served by this waiver is made up of individuals age 18 and under.

VII. DELIVERY SYSTEM

All services for the waiver population will be delivered through the current network of enrolled Medicaid providers.

Reimbursement for services provided to the waiver population will be based on the current Medicaid fee schedule.

VIII. ACCESS

A. Capacity

The Department of Community Health does not limit patient capacity for participating practitioners.

B. Outreach/Enrollment

Applications will be available at local Department of Family and Children Services offices. Information will also be available on the DCH website. This allows for a wide range of points of access into the program.

IX. QUALITY

The same grievance system in effect under the regular Medicaid program will apply to the waiver population. Recipients have available a formal appeal process under 42 CFR Part 431, Subpart E.

A. Eligibility

1. A quality control program for waiver participants that meets the requirements of Section 1903(u) will be implemented if necessary.

2. Applicants and recipients have available to them a formal appeal process under 42 CFR Part 431, Subpart E, to assure that they are not inappropriately denied enrollment or medical care or terminated from the program.

B. Surveillance and Utilization Review Subsystem (SURS)

1. The State's SURS is used to identify aberrant provider practices for education and potential sanction purpose.

2. To assure quality of services, SURS reviews payment files to identify over or under recipient utilization and patterns of aberrant provider behavior.

X. FINANCIAL ISSUES

See Attachment D.

Xl. SYSTEMS SUPPORT

The Medicaid Management information System (MMIS) and the statewide Division of Family and Children Services eligibility system (SUCCESS) will be modified as necessary to recognize the waiver recipients and the enrollment fee.

Xll. IMPLEMENTATION TIME FRAMES

The proposed effective date for implementation of the TEFRA Waiver Demonstration Program is April 1, 2004.

Xlll. EVALUATION AND REPORTING

The evaluation will be based on two objectives:

A. Cost neutrality, and

B. Access to quality care

XlV. WAIVERS

Section 1916(a)(2)(A) – Cost Sharing

A monthly premium will be required of waiver participants as outlined in Section Vl of the application.

ATTACHMENT A

List of Georgia Newspapers Used for Printing Statewide Notices

ALBANY HERALD PUBLISHING COMPANY

ATHENS DAILY NEWS

ATLANTA DAILY WORLD

ATLANTA JOURNAL & CONSTITUTION, ATLANTA VOICE, THE

AUGUSTA CHRONICLE,

COLUMBUS LEDGER & ENQUIRER

FULTON COUNTY DAILY REPORT

MACON TELEGRAPH,

MARIETTA DAILY JOURNAL

ROME NEWS TRIBUNE

SAVANNAH NEWS-PRESS

VALDOSTA DAILY TIMES

ATTACHMENT B

PUBLIC NOTICE

The Georgia Department of Community Health gives public notice of any significant proposed change in its methods and standards for services.

TEFRA ("KATIE BECKETT" OR "DEEMING") WAIVER PROGRAM PREMIUM PAYMENTS

Effective for dates of service on and after April 1, 2004, the Department is proposing a § 1115(a) demonstration waiver to impose cost sharing requirements on children age 18 and under who would otherwise be eligible for Medicaid under § 134 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").

Eligibility:

- The child under age 18 at the time of initial coverage.
- The child must be a United States citizen or qualified alien.
- The child must have a Social Security number or apply for one.
- The child must meet the SSI definition for disability.
- The child must meet the medical necessity requirement for institutional placement.
- The child must meet the income limit ("Medicaid Cap") used for institutional cases ($1656.00 per month in 2003). Parents' income will not be counted for the purpose of determining eligibility.
- The child's countable assets may not exceed $2000. Parents' assets will not be counted for the purpose of determining eligibility.
- Eligibility will be determined by the local Departments of Family and Children Services.

Premium Payments:

- All recipients will pay a monthly premium.

- Premium payments will be computed based upon the total income of the custodial parent(s) as reported on the most recent federal income tax return; i.e., line 22 of 2001 version of the IRS Form 1040 or line 15 of the 2001 version of the IRS Form 1040A. A copy of the return must be submitted upon application for coverage and as requested by the Department.

- The Department will allow limited deductions from the total income of the custodial parent(s) for the purpose of calculation of premiums. The following deductions will be authorized:

    - The Department will deduct $600.00 per child (either biological or adopted) if the child lives in the home of the custodial parent(s) and is listed as a dependent on the federal income tax return of the custodial parent(s).
    - The Department will deduct excess medical and dental expenses, as itemized on Schedule A of the custodial parent(s) federal income tax return.

- The maximum annual premium amount to be paid by any family will not exceed $5,500. The premium amounts are attached hereto as Appendix A.

- Families with more than one child on the waiver will pay only a single premium. There will be no increase in premium for additional children on the waiver.

- Premiums must be paid beginning with the first month following the month in which coverage is approved.

- The custodial parent(s) income will be reviewed, and the premium adjusted as necessary, on an annual basis.

- Additional adjustments may be made during the year, based upon a change (either an increase or decrease) in the income of the custodial parent(s) of more than 10%.

- Premium payments must be made via monthly automated bank draft or by quarterly advance payment. Failure to pay premiums will result in a loss of coverage for the month(s) for which a premium was not timely paid; failure to pay premiums for three months will result in deletion from the program and closure of the child's file.

- If a child's file is closed for non-payment of premiums, the family must reapply for coverage. The family must pay three months' premiums prior to resumption of coverage.

- If a child becomes ineligible for any reason other than non-payment of premiums, the family will be refunded any premiums paid for months after the child becomes ineligible for coverage.

- Premiums will be collected by the Department's contractor for this purpose (currently, DHACS).

- Notice of premium payment status will be sent to DFCS.

Other Health Insurance Coverage:

- Children will not be disqualified from participation in the waiver program solely because of other health insurance coverage. Regular Medicaid Third Party Liability rules will apply to this coverage.

- Children with other health insurance coverage whose family voluntarily drops the coverage will be ineligible for waiver benefits for a period of six months from the date that the coverage is dropped. A policyholder who violates the terms and conditions of a policy, resulting in cancellation of the policy, will be deemed to have voluntarily dropped coverage.

- The following circumstances will not be deemed to be a voluntary loss of coverage:

    - Loss of health insurance with a non-group or non-employer sponsored plan.
    - Loss of health insurance through termination of employment.
    - Loss of health insurance through no fault of the custodial parent(s).

Level of Care:

- The child must meet the medical necessity requirement for institutional placement. The Department's designee (currently, the Georgia Medical Care Foundation) will make this determination.

- The child must have access to medical care in the home. It must be deemed appropriate to provide such care outside of an institution.

- The estimated cost of care in the home must not exceed the estimated cost of care in an institutional setting.

Benefits:

- The benefit package will include the full range of Medicaid services.

- Children in the waiver program will be enrolled in Georgia Better Health Care ("GBHC").

- There will be no cap on the number of children who, if eligible, may be served under the program.

Changes:

The only changes to the program will be the premium charges and the imposition of sanctions on families who voluntarily drop health insurance coverage.

This public notice is available for review at each county Department of Family and Children Services office. Citizens wishing to comment in writing on the proposed changes should do so before February 11, 2004, to the Board of Community Health, P. O. Box 38406, Atlanta, Georgia 30334.

Comments so submitted will be available for review by the public at the Department of Community Health, Monday – Friday, 9:00 a.m. to 4:30 p.m., in Room 4074, 2 Peachtree Street, NW, Atlanta, Georgia 30303.

An opportunity for public comment will be held on February 11, 2004, at 10:00 a.m. in conjunction with the February meeting of the Board of Community Health. Individuals who are disabled and in need of assistance to participate during the meeting should call (404) 656-4479. The Board will vote on the proposed methodology after comments have been received. The February Board meeting will be held at the Carl E. Sanders Fireplace Room, Capital Education Building, 180 Central Avenue, Atlanta, Georgia.

NOTICE IS HEREBY GIVEN THIS 14th DAY OF JANUARY, 2004.

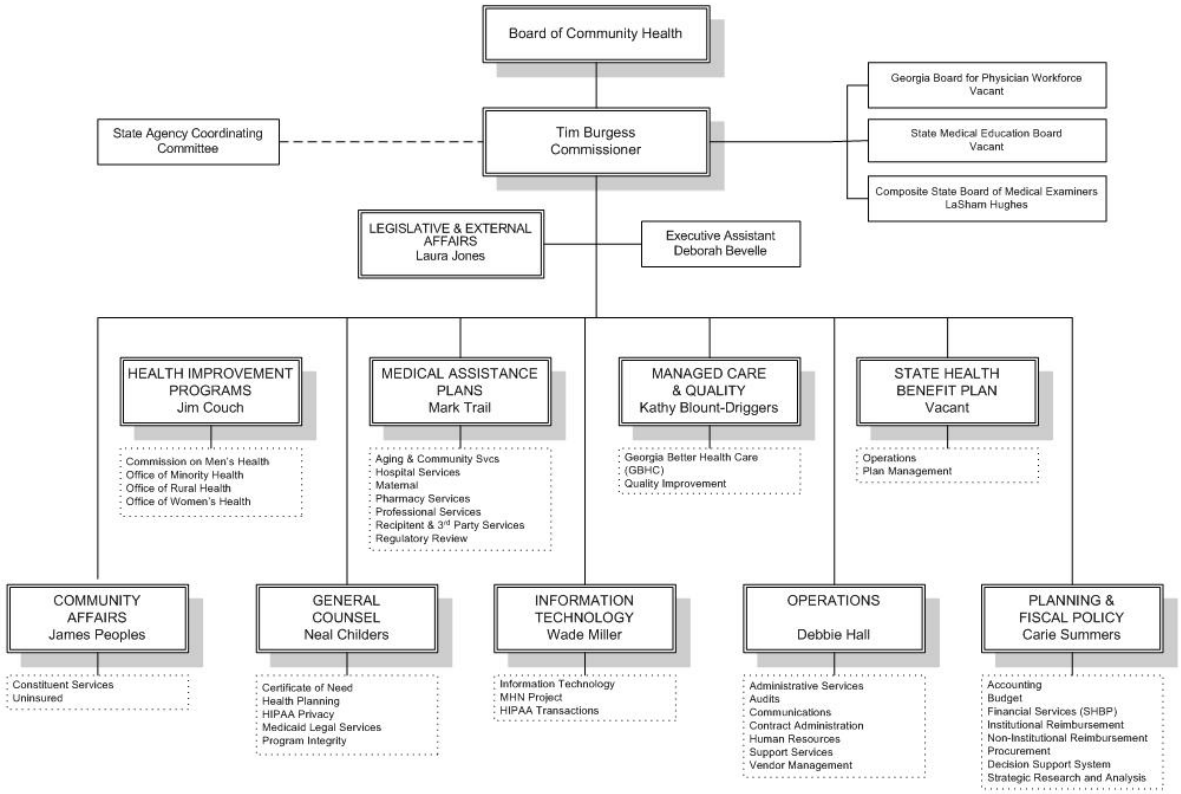
Tim Burgess, Commissioner

ATTACHMENT B

Income Level			Annual Premium	
Low	High	% of Income	$ Amount From	$ Amount To
$ -	$ 25,000	0.00%	$ -	$ -
$ 25,001	$ 50,000	1.00%	$ 250	$ 500
$ 50,001	$ 75,000	1.25%	$ 625	$ 938
$ 75,001	$ 100,000	1.50%	$ 1,125	$ 1,500
$ 100,001	$ 125,000	1.75%	$ 1,750	$ 2,188
$ 125,001	$ 150,000	2.00%	$ 2,500	$ 3,000
$ 150,001	$ 175,000	2.25%	$ 3,375	$ 3,938
$ 175,001	$ 200,000	2.50%	$ 4,375	$ 5,000
$ 200,001 over		2.75%	$ 5,500	$ 5,500

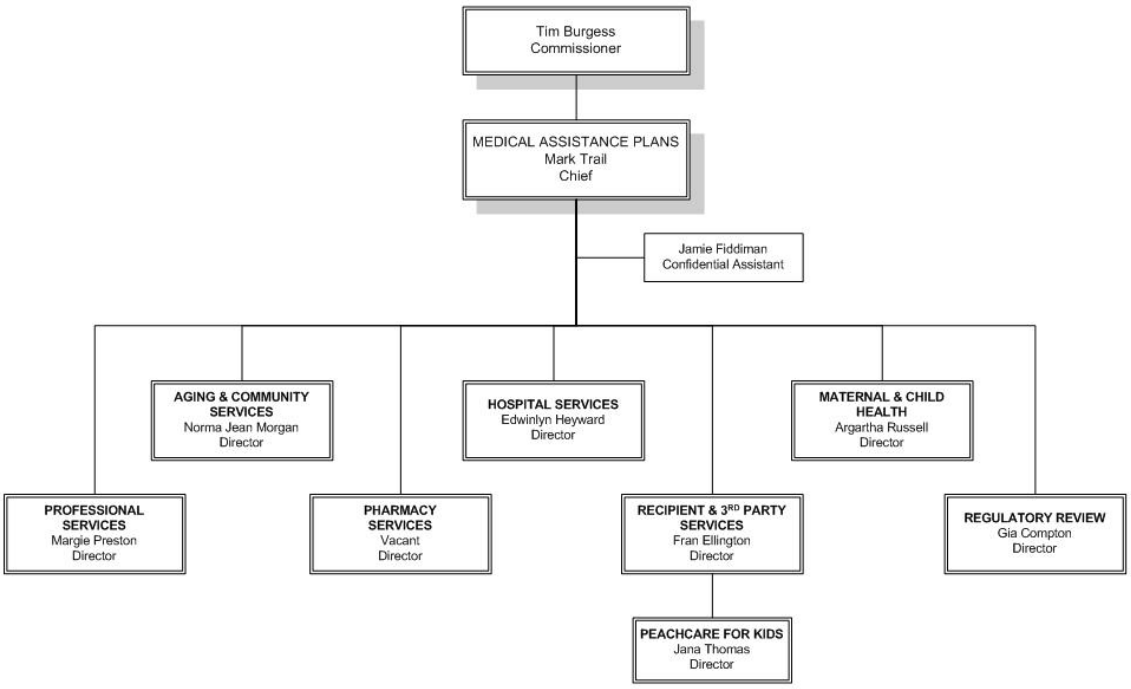
ATTACHMENT C

GEORGIA DEPARTMENT OF COMMUNITY HEALTH



Revised 10-01-03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAL ASSISTANCE PLANS



Effective 01-01-04

ATTACHMENT D

The narrative and attached schedules illustrate the budget neutrality for the Katie Beckett Deeming Waiver.

Data

All data reflected on the attached detail schedules are prepared by date of service based on the State Fiscal Year. Expenditures reflect those costs incurred by those currently eligible for the Katie Beckett Deeming Waiver. All claims data was derived from the Medstat Dataprobe System.

Baseline Without the Waiver

Expenditures were calculated and increased annually by the projected increase in utilization and medical costs based on past history and anticipated growth. SFY 04 projected expenditure growth = 10.78%
SFY 05 projected expenditure growth = 8.3%

Eligibles for both calculations were derived by looking at the current Katie Beckett population and applying an increase based on past history and anticipated growth. SFY 04 projected eligible growth = 5%
SFY 05 projected eligible growth = 3%

Baseline With Waiver

Expenditures were calculated and increased annually by the projected increase in utilization and medical costs based on past history and anticipated growth. SFY 04 projected expenditure growth = 10.78%
SFY 05 projected expenditure growth = 8.3%

Eligibles for both calculations were derived by looking at the current Katie Beckett population and applying an increase based on past history and anticipated growth. SFY 04 projected eligible growth = 5%
SFY 05 projected eligible growth = 3%

It was assumed that the Katie Beckett population was distributed among income levels similar to the Arkansas' TEFRA Waiver Model eligibles. Therefore the results of the TEFRA survey were applied to the Georgia population when determining premiums.

	FY 2003	FY 2004	FY 2005
Estimated Eligibles	6,049	6,351	6,542
Without Waiver			
Total Payment	$ 50,274,439	$ 55,692,985	$ 60,327,547
Less: Estimated COB Payments	$ 11,578,743	$ 12,826,692	$ 13,894,081
Net Payments	$ 38,695,697	$ 42,866,293	$ 46,433,466
PMPM	$ 533.09	$ 562.42	$ 591.48
With Waiver			
Total Payments	$ 50,274,439	$ 55,692,985	$ 60,327,547
Less: Estimated COB Payments	*$ 11,578,743*	*$ 12,826,692*	*$ 13,894,081*
Less: Estimated Premium Payments	*$ 3,733,114*	*$ 3,919,770*	*$ 4,037,363*
Net Payments	$ 34,962,583	$ 38,946,523	$ 42,396,103
PMPM	$ 481.66	$ 510.99	$ 540.05
Projected Program Savings	**$ 3,733,114**	**$ 3,919,770**	**$ 4,037,363**
Weighted Federal FMAP	0.6019	0.6255	0.6023
Federal	2,246,961	2,451,816	2,431,704
State	1,486,153	1,467,954	1,605,659
Total Savings	**3,733,114**	**3,919,770**	**4,037,363**

		Net Payment Projections by COS		
COS	COS Description	FY 2003	FY 2004	FY 2005
01	Inpatient Hospital	$ 3,022,357	$ 3,227,642	$ 3,423,007
07	Outpatient Regular	$ 4,785,740	$ 5,135,992	$ 5,508,548
11	SNF	$ 7,072	$ 6,355	$ 6,420
18	ICF/MR	$ 51,441	$ 51,811	$ 51,503
20	Home Health	$ 2,136,863	$ 2,125,370	$ 2,220,210
23	Independent Lab	$ 17,564	$ 17,787	$ 18,496
27	Family Planning	$ 821	$ 818	$ 900
30	Drug	$ 5,486,778	$ 6,086,694	$ 7,141,502
32	DME	$ 1,572,391	$ 1,535,498	$ 1,584,140
33	Prosth	$ 483,736	$ 476,760	$ 490,346
36	GAPP-Private Duty Nurse	$ 298,324	$ 335,683	$ 357,476
37	Ambulance	$ 47,635	$ 51,686	$ 55,847
43	Physician	$ 1,544,041	$ 1,576,901	$ 1,695,517
44	Outpatient Mental	$ 143,047	$ 144,865	$ 152,273
45	Dental	$ 479,748	$ 501,460	$ 513,417
46	Adult Dental	$ 18	$ 19	$ 19
47	Optometric	$ 27,179	$ 30,172	$ 31,349
48	Mid Wife	$ 192	$ 212	$ 216
49	Oral Max	$ 505	$ 522	$ 553
52	FQHC	$ 4,003	$ 4,166	$ 4,265
54	Rural Health	$ 888	$ 939	$ 966
55	Podiatry	$ 2,171	$ 2,414	$ 2,515
57	Psych	$ 220,655	$ 233,878	$ 232,738
59	Alt Health	$ 56,479	$ 59,068	$ 58,378
60	EPSDT	$ 66,670	$ 73,679	$ 79,604
65	At Risk of Incarceration	$ 7,994	$ 9,236	$ 10,557
66	Independent Care	$ 77,208	$ 74,670	$ 76,257
67	Amb Surg	$ 12,204	$ 14,713	$ 16,421
68	CCMR	$ 954,577	$ 1,116,833	$ 1,161,572
69	Hospice	$ 50,756	$ 53,441	$ 54,874
70	Protective Services - Child	$ 14,005	$ 16,036	$ 16,840
74	Nurse Practitioner	$ 12,088	$ 13,601	$ 14,485
76	Targeted Case Mgmt	$ 2,027	$ 2,404	$ 2,606
77	Model Waiver	$ 1,148,759	$ 1,332,434	$ 1,352,888
78	Physician's Assistant	$ 24,397	$ 25,942	$ 28,023
79	Rehab	$ 26,360	$ 27,013	$ 29,072
80	EIP	$ 856,162	$ 1,032,191	$ 1,069,403
84	Children Intervention Services	$ 13,404,335	$ 15,526,000	$ 16,924,282
85	GBHC	$ 1,388	$ 1,394	$ 1,431
87	Res Ther Svc	$ 227,358	$ 285,524	$ 302,963
88	CRNA	$ 8,503	$ 8,884	$ 9,037
92	Traumatic Brain Injury	$ 5,536	$ 5,785	$ 6,028
93	Community Alternative (SOURCE)	$ 1,462	$ 1,704	$ 1,819

94	MRWP (Brook Run Waiver)	$	285,307	$	310,163	$	305,875
96	CIS (School Services)	$	1,118,953	$	1,327,934	$	1,418,832
Totals		**$**	**38,695,697**	**$**	**42,866,293**	**$**	**46,433,466**
% increase					**10.78%**		**8.32%**
Unduplicated Recipients			5,565		5,844		6,019
Unduplicated Eligibles			6,049		6,351		6,542
	% Increase				5.0%		3.0%
PMPM		$	533.09	$	562.42	$	591.48
	% Increase				5.5%		5.2%

Income Levels		Median Income	Annual Premium based on Median Income		Population*		FY 2003		FY 2004		FY 2005	
			%	Amount	Survey	Percentage	Eligibiles	Annual Premium	Eligibiles	Annual Premium	Eligibiles	Annual Premium
$ -	$ 25,000	$ 12,500	0.00%	$ -	141	15.97%	966	$ -	1,014	$ -	1,045	$ -
$ 25,001	$ 50,000	$ 37,501	1.00%	$ 375	404	45.75%	2,768	$ 1,037,862	2,906	$ 1,089,755	2,993	$ 1,122,447
$ 50,001	$ 75,000	$ 62,501	1.25%	$ 781	226	25.59%	1,548	$ 1,209,548	1,626	$ 1,270,025	1,674	$ 1,308,126
$ 75,001	$ 100,000	$ 87,501	1.50%	$ 1,313	70	7.93%	480	$ 629,392	504	$ 660,861	519	$ 680,687
$ 100,001	$ 125,000	$ 112,501	1.75%	$ 1,969	21	2.38%	144	$ 283,226	151	$ 297,387	156	$ 306,309
$ 125,001	$ 150,000	$ 137,501	2.00%	$ 2,750	6	0.68%	41	$ 113,033	43	$ 118,685	44	$ 122,246
$ 150,001	$ 175,000	$ 162,501	2.25%	$ 3,656	7	0.79%	48	$ 175,330	50	$ 184,097	52	$ 189,619
$ 175,000	$ 200,000	$ 187,500	2.50%	$ 4,688	3	0.34%	21	$ 96,335	22	$ 101,152	22	$ 104,186
$ 200,001	And up	$ 200,001	2.75%	$ 5,500	5	0.57%	34	$ 188,389	36	$ 197,809	37	$ 203,743
Total					**883**	**100.00%**	**6,049**	**$ 3,733,114**	**6,351**	**$ 3,919,770**	**6,542**	**$ 4,037,363**

*Survey data represents data from Arkansas. It is assumed that Georgia's population distribution will be similar to Arkansas.